Mercy
HEALTH SERVICES

University Affiliated

Sponsored by the Sisters of Mercy

OFFICE OF THE PRESIDENT & CEO

June 6, 2005

Commissioner Robert E. Nicolay
Chairman, CON Program Task Force
Maryland Health Care Commission
4160 Patterson Avenue
Baltimore, Maryland 21215

Re: **Comments of Mercy Medical Center on the CON Review Process, State Health Plan, and the Maryland Health Care Commission Jurisdiction**

Dear Commissioner Nicolay:

Mercy Medical Center ("Mercy") appreciates the opportunity to submit comments to the Certificate of Need Task Force. Mercy supports the recommendations made by the Maryland Hospital Association ("MHA"). Mercy is also offering separate recommendations as set forth below.

I. THE BED NEED METHODOLOGY IN THE ACUTE CARE CHAPTER SHOULD BE REVISED TO CONSIDER HOSPITALS SERVING MULTIPLE JURISDICTIONS.

While the current jurisdictional bed need methodology may work in single hospital jurisdictions, it does not make sense in Baltimore City, where several hospitals have broad service areas based on programs that attract patients from outside of Baltimore City. For example, Mercy's tertiary programs in women's health, vascular surgery and orthopedics draw patients from outside of Baltimore City. The current methodology penalizes hospitals that serve other jurisdictions by limiting their projected bed need to only the demographic factors (e.g., population) in which the hospitals are located, for example, Baltimore City. Mercy recommends that the MHCC revise the methodology to allow hospitals whose service area is multi-jurisdictional to benefit from population growth occurring within the respective hospital's service area. The MHCC should also consider historical growth of hospitals of this type in projecting future bed need.

301 ST. PAUL PLACE BALTIMORE, MD 21202-2165 (410) 332-9521 FAX (410) 962-1303
TTY (410) 332-9888 E-MAIL tmullen@mercymed.com

II. THE CERTIFICATE OF NEED ("CON") REVIEW PROCESS SHOULD BE STREAMLINED WHEREBY CERTAIN TYPES OF PROJECTS SHOULD BE REVIEWED ON AN EXPEDITED BASIS.

Several parties, including the MHA, will offer comments on the CON Review Process including the efficiency related to how the "completeness" questions have slowed decision-making by the Commission. More importantly, Mercy recommends that the Commission should develop a process to "fast-track" certain projects that involve: (1) renovation or replacement of existing physical plant without the addition of new beds or services; (2) new construction projects that do not involve the addition of new beds or services; and (3) implementation of clinical information technology (unless the Commission chooses to deregulate this type of capital expenditure). Projects qualifying for expedited review should be "deemed" approved with a CON issued 90 days after docketing if either Staff review is not completed within 60 days of docketing or the Commission decision is not rendered within 90 days.

III. SEVERAL ASSUMPTIONS IN THE STATE HEALTH PLAN SHOULD BE CHANGED.

A. The State Health Plan should be revised to be consistent with the bed licensing law.

Several years ago, Maryland law was revised and now includes a process whereby the number of licensed acute care beds (medical, surgical, obstetric, pediatric, and psychiatric) is changed each year. Specifically, this "bed licensing law," or "140% rule" provides that the number of licensed beds shall be equal to 140% of a hospital's average daily census ("ADC") during the prior year. For example, if a hospital's ADC was 100, that hospital would be licensed to operate 140 acute care

beds in the subsequent year. Hence, the 140% licensure rule is the equivalent of 71.4% occupancy (100 ÷ 140 = 71.4%). To project need in the State Health Plan, the Commission uses occupancy assumptions that are greater than the 71.4% occupancy mandated by the bed licensing law. For instance, the Acute Care Chapter projects gross jurisdictional medical/surgical bed need based on an 80% "jurisdictional minimum occupancy" for hospitals with ADC's between 100 and 299 patients. However, the number of beds actually licensed at a hospital of this size will be based on 71.4%, the lower statutory standard. The General Assembly's policy determination that acute care hospitals should operate at 71.4% occupancy should be incorporated into the State Health Plan.

B. The "Target Year" in the State Health Plan Should Be Extended.

The Acute Care Chapter currently projects need eight years in the future. The current medical/surgical bed projections are 2010, eight years after the base year data used in making that projection. Mercy understands that the Acute Care Chapter projection will soon be updated and extended to 2012, based on 2004 data which are now available.

Mercy believes that the Commission should use a ten-year, rather than a eight-year planning "horizon" so that the soon-to-be-performed update would identify need for 2014, rather than 2012. Extending the planning horizon in this manner enables hospitals to better plan their future needs over the long-term. As discussed below, an alternative to extending the planning horizon would be to permit hospitals to: (1) build shell space in instances when it would be more cost-effective to do so now rather than adding that space in the future: or (2) replace existing antiquated space without demolishing that space or simultaneously converting it to another use.

C. Hospitals Should Be Permitted to Construct "Shell" Space or Replace Existing Antiquated Space Without Demolishing That Space or Simultaneously Converting That Space to Another Use.

At present, many Maryland hospitals with aging physical plants are submitting proposals to replace that space. As noted above, the occupancy assumptions in the Acute Care Chapter will result in hospitals licensing fewer beds than Maryland law actually allows, assuming that the State Health Plan patient day projections are correct. In addition, hospitals proposing large capital projects to replace existing physical plant must plan for future years, not just up to the State Health Plan "target" year, currently 2010.

To permit hospitals to address future needs, Mercy recommends that the State Health Plan be revised to provide that hospitals may construct or create "shell" space, as part of a new project under certain circumstances. As part of this change, Mercy also recommends that hospitals that are "land-locked" be allowed to replace existing antiquated inpatient space, even though that space will not be demolished or be converted to a different use simultaneously. At present, Commission Staff focuses on physical capacity in assessing whether new capacity may be constructed. If existing space is no longer consistent with modern standards and a hospital proposes to delicense that space as a result of a new construction project, hospitals should be able to be allowed to proceed in that manner.

IV. CERTAIN CON STANDARDS SHOULD BE MODIFIED OR ELIMINATED.

Several parties will identify a number of CON standards that require either modification or possibly elimination. The most important CON Standard requiring modification is Section .06B(9) in the Acute Care Chapter which identifies the maximum amount of departmental

gross square feet for new construction projects. These existing standards are out-of-date and are not being used in CON reviews. Instead, recommendations made by a Commission Staff Work Group are being used, even though they are not part of the State Health Plan.

Mercy recommends that this standard be updated to reflect AIA Guidelines, new patient safety standards, and the "move" to constructing new facilities or additions with all private rooms. In establishing new standards, Mercy recommends that the Commission review how other states address this topic.

Mercy also incorporates by reference and supports the MHA recommendation that virtually all of the system standards in the Acute Care Chapter, as well as other standards, be eliminated. In Mercy's view, the test for including a standard should be whether that requirement is a basis upon which the Commission would deny an application. Checklist criteria, including submission of admission, discharge, and other hospital plans and protocols, as well as filing transfer agreements, are of no use in assessing whether a hospital project should be approved. As the MHA submission notes, there are other regulatory agencies and requirements that focus on these topics. Indeed, to Mercy's knowledge, no CON applicant has ever failed to produce the required material and no CON application has ever been denied on the basis of these standards.

Thank you again for the opportunity to submit these comments.

Very truly yours,

Thomas R. Mullen
President and CEO

cc: Mr. Samuel Moskowitz
Ms. Judy Weiland
Andrew L. Solberg
Jack C. Tranter, Esq.